Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $4,366.41 for date of service 03/14/01.

   b. The request was received on 03/05/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. Response to a Request for Dispute Resolution
   b. HCFA(s)
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 12/09/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 12/10/02. The response from the insurance carrier was received in the Division on 12/23/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request.

4. Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 10/28/02

> "The Carrier failed to provide an adequate response to the request for reconsideration and has not forwarded any additional information indicating the Carrier's denial of additional payment. Based upon the initial denial presented by the Carrier, it is the requestor's position that the Carrier is required to pay the entire amount in dispute."

2. Respondent: Letter dated 12/23/02

> "It appears that the Provider paid a fair and reasonable rate for the above referenced services. The EOBs show that certain services were reduced and paid and that others were not reduced or paid. It appears that certain reductions were made pursuant to a PPO contract, and others were reduced as a result of a reduction because of the service not having a MAR value or the service having no value and/or reduction according to the Medical FEE Guidelines."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/14/01.

2. The Provider billed the Carrier $13,645.02, for the date of service 03/14/01.

3. The Carrier made a total reimbursement of $9,278.61 for the date of service 03/14/01.

4. The amount left in dispute is $4,366.41 for the date of service 03/14/01.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

The MFG reimbursement requirements for DOP states, "An MAR is listed for each code excluding documentation of procedure (DOP) codes… HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate."

Medical documentation submitted indicates these charges are for a rotator cuff tear, impingement. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence in regards to fair and reasonable. The provider has not submitted additional reimbursement data for the charges billed for similar services. The carrier, according to their denial on the EOB, asserts that they have paid a fair and reasonable reimbursement, but have not submitted a methodology to support their reimbursement. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
3. reference its method in the claim file; and
4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;". The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. However, the provider has the responsibility to support their charges are fair and reasonable as the requestor. In this case, the Requestor has not provided documentation to support their position that the amount billed is fair and reasonable. Therefore, additional reimbursement **is not** recommended.

The above Findings and Decision are hereby issued this 12th day of February 2003.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb